weight was observed, but no relation at all between weight gain and smoking during pregnancy was found. Moreover, the absence of difference in placental weight, as well as the existence of histological signs of hypoxia in the placentæ of smoking women[2] enable one to suggest that smoking has a direct effect on placenta and fetus, even it is not the only effect.

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WOMEN IN MEDICINE

SIR,—Thank you for your helpful editorial (June 12, p. 1280) on the problems facing women in medical practice. It seems that these difficulties arise nowadays not so much from decisions reached by men deliberately designed to harm the careers of women doctors but more from a failure to consider these matters at all. Though there has been some recent consideration of these subjects by some medical writers, both male and female, it is interesting to note that your editorial (no doubt not meant to be exhaustive) contained no references dated between 1623 and 1975.

What is now required is that consideration be given to the specific problems of a sizeable minority of the profession. When medical women were a rarity it was perhaps understandable that their difficulties were neglected. Now around a fifth of the profession are female, and with the abolition of the quota system for admission to medical schools it can be anticipated that the proportion of women doctors will rise to perhaps half by the end of the century. The implications of this change on medical staffing patterns in the U.K. cannot any longer be ignored.

We will have to introduce flexible training schemes to enable women with family commitments (and, indeed, some men) to acquire skills needed by the community and so to achieve their own potential. Failure to do this may mean that the current doubling of medical-student numbers will in the end produce few more working doctors than are now produced. The waste, both in financial and in human terms, is more than we should be prepared to accept. A start was made in this direction by the part-time training posts for women doctors with family commitments introduced by the D.H.S.S. in 1969. Such posts are no longer funded by the Department but by the regions, as a consequence of the 1974 reorganisation. Now, when a hospital wishes to make such an appointment and has a woman doctor wishing to take it up, the regions say they have no funds. Here is an actual deterioration of the situation. Perhaps, since we no longer have a female Secretary of State nothing else can be expected. We do, however, still have a Chief Medical Officer at the D.H.S.S. who confesses to "a terrible sense of guilt for his own sex". Perhaps he could expiate some of his guilt by solving this limited problem.

The Medical Women's Federation is the only organisation whose sole concern is the promotion of the interests and careers of women doctors. It is considering what to do about the representation of its views to Government and within the councils of the profession. I urge all medical women to join the M.W.F. in order that their views may be heard, in an attempt to avoid repeating the mistakes of the past.

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Hon. Secretary

SIR,—Your editorial was most interesting reading. A small group of fully trained doctors find themselves at a gross disadvantage due to their sex, and I reciprocate your sentiments. All the arguments that you have made for the women doctors can easily and equally be made for the overseas doctors who contribute 27% of the medical manpower of the National Health Service and whose fate in the hands of employers relating to training and discrimination is, perhaps, worse than that of women. I hope that the suggestions made by the Community Relations Commission and noted by you on June 19 (p. 1361) will be supported.

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SIR,—Dr Sterling's article (June 12, p.1285) and your editorial in the same issue have again drawn attention to some of the problems of woman (or, of course, other) doctors who can work only part time. Dr Sterling shows the high standard of training that can be achieved on a part-time basis but stresses that more part-time consultant posts need to be created by regional health authorities. While concurring in this I feel that many women still meet problems at the training stage. Not all regions are as far-sighted as Wessex which "has shown that, despite decentralisation of funds, an appropriate budget can be created" for part-time training. On the question of finance HM(69)6 merely states that "while no special additions will be made to revenue allocations, hospital authorities are asked to provide in future estimates for the cost of retraining women doctors and of arranging for their re-employment". Although some regional hospital boards previously allocated funds specifically for the purpose, some regions are now telling districts that the moneys must be met from their own budget. Naturally, in this time of financial stringency, requests for such posts are unlikely to succeed.

This policy (or lack of it) is short-sighted. Increasing numbers of women are being admitted to medical schools, and future staffing of the N.H.S. will depend on adequate provision for part-time work, whether for continuing training or for retraining.

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D.N.A-ASE IN TREATMENT OF INFECTIOUS MONONUCLEOSIS

SIR,—There is no specific therapy for infectious mononucleosis (I.M.) and symptomatic treatment (antimicrobial agents, salicylates, corticosteroids) fails to shorten the course of the disease. I.M. is now thought to be a self-limited lymphoma-like illness caused by the herpes-like D.N.A.-content Epstein-Barr virus (E.B.V.) or a closely related one which, however, in some people may produce a malignant lymphoma. The evidence for this statement is based on histological (Reed-Sternberg cells), cytological, virological (E.B.V.), serological (heterophilic E.B.V.-antibodies), and epidemiological (increased risk of Hodgkin's disease in patients with previous I.M.) features.[1,2] Multiplication of D.N.A. (viruses of herpes, adenoviruses) may be suppressed with pancreatic D.N.A.-ase (E.C. 3.1.4.5). In clinical trials, D.N.A.-ase proved to be effective against adenoviral conjunctivitis, herpetic keratitis, and herpes zoster.[3]

Assuming a viral ætiology and taking into consideration the activity of D.N.A.-ase in diseases caused by D.N.A. viruses a comparative study of therapeutic effectiveness of D.N.A.-ase in patients with I.M. was undertaken. In the trial were 30 patients, 23 males and 7 females, aged 15–22 years at the time of illness (1973–75). All patients had characteristic clinical (fever, tonsillitis, adenopathy, enlarged liver and spleen, rash), hæmatological (absolute lymphocytosis with increased

2. Spira, A., Philippe, E., Spira, N., Dreyfus, L., Schwartz, D., *VIIIth Wed. congr. Gynec. Obstet.* (in the press).

1. Mackinney, A., Cline, W. *Br. J. Hæmat.* 1974, 27, 367.
2. Rosdahl, N., Larsen, S. O., Clemmesen, J. *Br. med. J.* 1974, ii, 253.
3. Salganik, R., Mosolov, A., Trukhachev, A., Pankova, T., Tomsons, V. *9th int. congr. Microbiol.* 1966, abstr. p. 544.

number of atypical forms), and serological (positive heterophilic reaction) features. Randomisation assigned 15 patients to D.N.A.-ase and 15 to symptomatic treatments (antibiotics or low doses of prednisolone).

D.N.A.-ase (Leningrad Plant of Medical Preparations) with activity of 5000–6000 units of activity according to Kunitz was given intravenously, 1·4 mg/kg/day, over 7 days.

As a result of D.N.A.-ase treatment a rapid regression of all pathological signs of the disease was noted as compared with control group: fever (1·9 *v.* 5·1 days, $P<0·01$), tonsillitis (4·0 *v* 7·1, $P<0·05$), adenopathy (7·5 *v* 11·6, $P<0·05$), and enlargement of spleen (6·0 *v* 12·4, $P<0·01$) and liver (5·7 *v* 12·1, $P<0·01$). A rash, which developed in 4 cases, disappeared more rapidly in 2 treated patients. D.N.A.-ase had a positive influence on the peripheral blood causing a decrease in atypical lymphocytes. These results indicate that D.N.A.-ase has a therapeutic effect in this lymphoma-like viral disease.

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TREATMENT OF VARICOSE VEINS

SIR,—Mr Burnand and his colleagues (May 6, p. 936) conclude that surgery for stasis ulcers is doomed to failure when the deep veins are incompetent. The conclusion might be expanded to state that surgery alone ultimately results in failure.

Their assessment includes the following statements:

(1) "At review 25 were still attending outpatients and 32 patients had been discharged." Conclusion: 32 patients were no longer under medical care, at least not by the surgical team that carried out the operation.

(2) "The group still attending hospital were interviewed in the outpatient department and questionnaires were sent to the remainder." Conclusion: if I understand this statement, none of the 57 patients were at the time of the report being actively followed by the authors.

(3) " 'Has your ulcer recurred since operation?' was the only question asked." Conclusion: no inquiry was made about treatment received by other physicians or about the following of any instructions that might have been given at the time of discharge.

The postphlebitic syndrome is a lifelong disability regardless of the treatment. Any treatment administered without continued control of the œdema (which inevitably occurs) and meticulous attention to the care of the skin, is certain to fail. Unless Mr Burnand and his colleagues can provide more information, the conclusion remains that surgical treatment of the postphlebitic syndrome without ongoing care is doomed to failure.

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*** This letter has been shown to Mr Browse and Mr Burnand, whose reply follows.—ED. L.

SIR,—We would not disagree with Dr Strandness' conclusions provided he accepts our definition of the postphlebitic syndrome—i.e., œdema, thickening, pigmentation, and ulceration in the presence of phlebographically demonstrable deep-vein damage, not perforator incompetence with normal deep veins. We hope the following points will clear up his minor misconceptions:

(1) The 25 patients (which included all 21 patients with postphlebitic changes on phlebography) were all continuing to attend our outpatients. Any additional therapy has proved to be of no benefit to 21 of these patients.

(2) The 32 patients who had been discharged from the clinic and were sent the questionnaire had had no postphlebitic changes on preoperative phlebography, and received no advice or additional treatment because the surgical treatment had been successful. We do not consider it necessary to follow up these patients.

(3) We feel that ulceration is the only complication of the postphlebitic syndrome which can be objectively assessed by a questionnaire.

We await evidence that surgery to the superficial veins in patients with extensive post-phlebitic damage of their deep veins confers any additional benefit over treatment with elastic stocking support and possibly fibrinolytic enhancement[1] in preventing recurrent ulceration.

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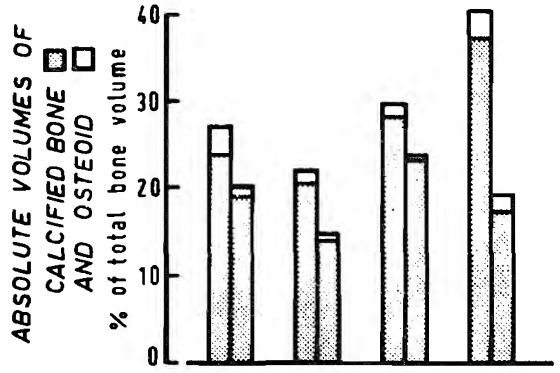
K. G. BURNAND

1α-H.C.C. IN CHRONIC RENAL FAILURE

SIR,—Dr Tougaard and his colleagues (May 15, p. 1044) seem surprised at their observation that 1α-hydroxycholecalciferol (1α-H.C.C.) was ineffective in preventing calcium loss from bone in their uræmic patients. Nevertheless they assume that the dose of 1α-H.C.C. was sufficient because plasma-calcium rose to normal in most patients and became abnormally high in some. A well-known physiological action of vitamin D is mobilisation of calcium from bone deposits, so it might be more correct to predict, at least in a first period of treatment with vitamin D or its hydroxy compounds, an improvement of the osteoid/calcified tissue ratio while the absolute volume of calcified tissue might decrease.



Absolute volumes of calcified bone and osteoid in each of four uræmic patients before (left) and after (right) therapy with high doses of Cholecalciferol.

Our experience is based on four selected uræmic patients treated for six months with large doses of vitamin D_3 (600 000 units/week). Bone, taken at biopsy before and after treatment, exactly quantified using the image analysing computer of the University College Hospital Medical School, London. The figure shows a diminution of the calcified area in all the treated patients, while biochemical, radiological, and hormonal investigations demonstrated a general improvement of the uræmic osteodystrophy.

We conclude that only after a longer term trial will we be able to find out what happens to uræmic bone disease, because it is probable that an increase of calcium content of bone may take place only after a more prolonged hypercalcæmia. Qualitative and quantitative histological data will be necessary for these studies.

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1. Jarrett, P. E. M., Burnand, K. G., Morland, M., Browse, N. L. *Br. J. Surg.* 1976, **63**, 157.